EXHIBIT B

We Will Only Accept D...iveries From UNION Carriers! All O...er Deliveries Will Be Refused!

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AUG 09 2002

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AUTHORIZATION TO RELEASE INFORMATION AND REIMBURSEMENT AGREEMENT

1. Please complete Parts I and II.
2. Please sign the form and ***have it notarized*** in Part III.
3. Please return the form to the Fund Office with the claim form.

PART I – AUTHORIZATION TO RELEASE INFORMATION

The signature in Part III will apply to both this Authorization and to the Reimbursement Agreement

To all physicians, hospitals, medical service providers, druggists, employers, and all other agencies or organizations. (This includes other insurers. Blue Cross-Blue Shield and prepaid health plans.):

For claim purposes, I agree that the Fund Office or its representatives may see, or obtain a copy of all records* which pertain to DAVID MENDES ([redacted]).
(Member's Name)

Unless limits are shown below, this form pertains to all of these records: medical, mental and dental care, drug or alcohol use, prescribed drugs, employment and insurance coverage records. This information is for the sole use of the Teamsters Local 251 HSIP, which will process the claim.

I can revoke this authorization by giving notice to the Fund Office. The notice will not apply to information released before the date the Fund Office has the notice. If not revoked, this form will be valid while the claim is pending, but not more than one year from the date it is signed.

I agree that a photocopy of this form will be as valid as the original. Anyone signing this authorization may have a copy of it, upon request.

*Limits, if any:

_____

_____

EXPIRATION DATE: SEPTEMBER 17, 2002

PART II – REIMBURSEMENT AGREEMENT

The signature in Part III will apply to both this Reimbursement Agreement and to the Authorization.

As a covered employee under Teamsters Local 251 HSIP, I have filed a claim for Weekly Accident and Sickness (WA&S) benefits.

I request that Teamsters Local 251 HSIP honor my claim for benefits as *(check one)*:

☐ I have filed and **been denied Workers' Compensation benefits** and filed my petition of appeal. My attorney' name is: _____ and his/her phone number is: _____.

☐ I have filed for and am **awaiting a decision notice regarding my Workers' Compensation claim.**

☐ I have **not filed** for Workers' Compensation benefits as I am **unsure whether my disability is work related.**

☑ I have **not filed** for Workers' Compensation benefits as I am **sure that my disability is not work related.**

☑ I **have been in an automobile accident** in which I am seeking compensation. My attorney' name is: Karen Alegria and his/her phone number is: 508-676-3407.

I understand that if I receive any WA&S benefits for a period for which I am determined to be entitled to Workers' Compensation or similar benefits, the Fund must be reimbursed for those WA&S benefits.

I understand that as of my date of Pension I am no longer eligible for this benefit, and that it is my responsibility to reimburse the Fund for any overpayment that I may receive.

I agree to reimburse Teamsters Local 251 HSIP for the amount of benefits paid to me for this disability from any other source. I acknowledge the Teamsters Local 251 HSIP may file a lien to the extent of any Weekly Accident & Sickness benefits paid.

PART III – SIGNATURE

The signature in this Part III will apply to both the Authorization and to the Reimbursement Agreement.

D. A. Mendes — Signature of Member

David A. Mendes — Member's Name (please print)

Notary Public — my commission expires 6/23/05 — Term Expires

If signed by someone other than member, signature of that individual and relationship.

Signature of other than Member

Relationship to Member